VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

May 24, 2011

Ms. Jessica Jennings, Administrator
Saint Albans Healthcare And Rehabilitation Center
596 Sheldon Road
Saint Albans, VT 05478

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 27, 2011.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	04/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

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F 000	INITIAL COMMENTS An unannounced annual recertification survey was conducted by the Division of Licensing and Protection from 4/25/11 to 4/27/11.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and confirmed through staff interview the facility failed to assure that all resident areas were maintained in a sanitary and comfortable manner. Findings include: During tour of the physical environment with Maintenance Staff #1 on the morning of 4/27/11, the following observations were made: 1. There was crumbled paint, and/or loss of sheet rock exposing interior wall board, on the walls behind the toilets in the bathrooms of rooms #11, #18, #24 and #25 on the East Wing. The deteriorated areas of wall were centered around plumbing fixtures and located directly below the faucet handles and hose utilized by staff to clean bedpans. Maintenance Staff #1 stated, at the time of tour, that there was a water drainage problem with the plumbing connected with the bedpan cleaner hoses creating damage to the walls. 2. There was dirt and wax build up along the edges of the floor of room E-25, near the entrance door, closet and sink areas, as well as	F 253	F253 St. Albans Health & Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. Residents on the East Unit rooms #11, #18, #24, And # 25 have the potential to be affected by this deficient practice. A contractor, B&D Construction, has been obtained and will be at the center on 5/19 to review the job, give an estimate, and schedule a start date to repair the walls behind the toilets in the mentioned rooms.. All resident's rooms will be audited with appropriate repairs made as needed. East neighborhood room #25 was provided with a "complete room clean" to include stripping and waxing of the bedroom as well as the bathroom. The mentioned commode was removed by the DON and disposed of immediately on April 26, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 5.17.2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 throughout the bathroom floor in that room. In addition, there was a commode placed over the toilet seat in the bathroom of the same room that had paint chipped off the front of the seat exposing a rust covered area. 3. The resident shower room located on the West Wing had tile missing from the corner wall between the 2nd and 3rd shower stalls. All observations were confirmed by Maintenance Staff #1 at the time of tour, as well as by the facility Administrator during a second tour, at 10:40 AM on 4/27/11. The Regional Vice President of Operations stated, during interview at 10:20 AM on 4/27/11, that the maintenance staff had been reduced by a full time staff member for the past 2-3 months and because of the reduced staff it had "put them behind."	F 253	Abel Glass & Tile will be at the center on 5/18 for the west wing shower room to provide an estimate and start date to repair the missing tiles between the 2nd & 3rd shower stall. A new Director of Maintenance and Director of housekeeping/laundry have been implemented. The environmental services department will have received education regarding identification and reporting of potential environmental hazards by May 27, 2011. Environmental rounds will be completed twice per week x 90 days to assure all resident areas are maintained in a sanitary and comfortable manner. These rounds will be completed by the Maintenance Director and the Housekeeping Director. Audits will be reviewed during the quarterly QA meetings. Corrective Action completed by May 27, 2011.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed through staff interview the facility failed to assure the resident environment was maintained in a manner as free from accident hazards as possible. Findings include:	F 323	F253 POC Accepted 5/19/11 K Campos RN/PM Cota RN St. Albans Health & Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. All residents have the potential to be affected by this deficient practice.	

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F 323	Continued From page 2 During tour of the physical environment, with Maintenance Staff #1, on the morning of 4/27/11, the following observations were made: 1. There were multiple areas of rough, jagged surfaces on the wooden hand rails located in resident care areas throughout the facility creating a potential hazard for splinters or other injury to upper extremities of residents. 2. The wooden wall board, approximately a foot wide and adhered to the interior walls of the facility at a height approximately 1 foot above the floor, had large areas, at the junction of 2 walls on both the East Wing Unit and at the corner of Champlain Blvd and Market Street hallways, where the wood had been gouged out leaving the edges rough and jagged in spots creating the potential for injury to resident lower extremities if walking or pushed in wheelchairs. 3. There was a metal heating element located on the floor in the hallway near the exit door of East Wing that was missing the end cap exposing sharp metal edges, creating the potential for lower extremity injury for residents walking in the area. 4. There was a ceiling tile located outside of room E- 26 that was bulging, cracked and broken with dust and debris hanging from a hole in the tile and floating to the hallway floor. Maintenance Staff #1 stated, at the time of tour, that there had been an ongoing intermittent problem with the roof of the facility in that area, which had been "patched" previously. S/he also stated that there had been water leaking from the ceiling tile during	F 323	All hand rails have been inspected and repairs made as required. Hand rails in resident living areas will be inspected weekly x 4 weeks then monthly x 3 with repairs made as needed. Pricing for replacement with synthetic material is being obtained. Results from these audits will be presented in the quarterly QA meeting x 2 by the Maintenance Director. Wall protection wooden bumpers: all damaged wooden boards will be replaced by May 27, 2011. bumpers will be audited related to their general condition weekly x 4 weeks then monthly x 3 with repairs made as needed. Results will be presented at the quarterly CQI x 2 by the Maintenance Director. Base board heater: a new end cap has been fabricated and installed. All corridor base board heaters will be audited weekly x 4 weeks then monthly x 3 with repairs as needed. Results of these audits will be presented during the quarterly CQI x 2.	

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F 323	Continued From page 3 a rainstorm that had occurred the night before the observation was made. 5. The corner wall between the first and second shower stalls, located inside the shower room utilized by residents of both East and Center Wings, had tile missing leaving a hole with a piece of jagged metal exposed. All observations were confirmed by Maintenance Staff #1 at the time of tour, as well as by the facility Administrator during a second tour, at 10:40 AM on 4/27/11. The Regional Vice President of Operations stated, during interview at 10:20 AM on 4/27/11, that the maintenance staff had been reduced by a full time staff member for the past 2-3 months and because of the reduced staff it had "put them behind."	F 323	The mentioned ceiling tile on the East Neighborhood was replaced on the morning of April 27th by the Maintenance Director. ceiling tiles will be audited weekly x 4 weeks and monthly x 3 with results of the Audits presented by the Maintenance Director during the quarterly CQI x 2. A capital expenditure plan is in place to repair the roof; half this year and the second half next year. The East wing shower room is scheduled on 5/18 to be reviewed by Abel Glass & Title to repair the corner wall between the first and second shower stall. Corrective action will be completed by May 27, 2011.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	F 334	F323 POC Accepted 5/19/11 K Campos RN/ PMcotaRN F334 St. Albans Health & Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. Resident #107 is the only resident out of the five reviewed that is at risk of being affected by this deficient practice. Resident #107's DPOA signed a declination form as this resident had already received the pnuemococcal vaccine prior to his admission.	

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F 334	Continued From page 4 following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5	F 334	Education has been provided to the center Nurses regarding the Policy and Procedure For Immunizations: Influenza/Pneumococcal. Education will be complete by May 20, 2011. The Director of Nursing and/or her designee will perform a weekly audit of new admissions X 4 weeks and then monthly x 3 to assure that the resident has been offered the pneumococcal vaccine and education has been provided per the center's P&P. These audits will be presented during the quarterly CQI meetings x 2 to ensure compliance is met. Corrective action will be completed by May 27, 2011. F334 POC Accepted 5/19/11 K.Campos RN/QM Coord RN	

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F 334	Continued From page 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interview the facility failed to determine the pnuemococcal immunization status, and/or offer the immunization, to 1 of 5 residents in the targeted sample. (Resident #107). Findings include: 1. Per record review there was no evidence of Resident #107's pnuemococcal immunization status. Although the resident was admitted to the facility on 3/8/11, there was no documentation, as of 4/27/11, that staff had determined whether the resident had received the immunization prior to admission. In addition, there was no documentation that staff had offered the pnuemococcal immunization, or provided education regarding the benefits and potential side effects of the immunization, thereby providing an opportunity for the resident/resident representative to decline it. This information was confirmed by the DNS (Director of Nursing Services), during interview at 2:30 PM on 4/27/11.	F 334		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 6 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed through staff interview the facility failed to assure that	F 441	F441 St. Albans Health & Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. All residents have the potential to be affected by this deficient practice. All nursing and housekeeping staff will be educated by May 20, 2011 regarding the policy for infection control and potential for contamination of resident equipment. The Director of Nursing and/or her Designee will perform weekly audits X 4 weeks and then monthly x 3 to assure that resident equipment is maintained properly. Audits will be presented at the quarterly CQI x 2. Corrective action will be complete by May 27, 2011. F441 POC Accepted 5/19/11 KCampos RN/QMcotaRN	

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F 441	Continued From page 7 resident equipment was stored in a manner that would prevent the potential for contamination. Findings include: 1. Per observation during initial tour, on the morning of 4/25/11, a soiled urine collection container was stored, uncovered, directly on the floor of the shared bathroom between rooms #CE-6 and #CE-8. The container was labeled with the name of a resident who had been discharged on 4/22/11. The DNS confirmed the storage of the urine collection container, which was still stored on the bathroom floor during tour and interview the following day, at 4:40 PM on 4/26/11. S/he also confirmed that the resident whose name was on the collection container had been discharged on 4/22/11, and stated that the collection container should not be stored on the floor. 2. During tour of the facility, with a Maintenance staff member on the morning of 4/27/11, a soiled urinal was stored uncovered, directly on the floor next to the toilet in the bathroom of room #E-25. This was confirmed, at the time of the observation, by LNA #1 who stated that the urinal should not have been stored on the floor.	F 441		